

**Integrative Health Systems, P.S.**

**Douwe Rienstra, MD**

Monroe Street Medical Clinic

242 Monroe Street

Port Townsend, WA 98368-5709

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**PLEASE PRINT**

**PATIENT** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ M  F   
First name Middle Last

For positive identification and linkage of your medical records to you and you only, please provide  
Drivers license number \_\_\_\_\_ Last 4 digits of your social security number \_\_\_\_\_

Please address me by my first name last name If married, name of spouse \_\_\_\_\_

If minor, name of parent or legal guardian \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Email address \_\_\_\_\_ @ \_\_\_\_\_ for our popular monthly newsletter

PHONE: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Message \_\_\_\_\_ IF FROM OUT-OF-TOWN, please give a local phone no \_\_\_\_\_

Personal and secure FAX number for lab results and medical reports: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_  
Address and/or phone number \_\_\_\_\_

**Emergency Information**

NAME OF RELATIVE, FRIEND OR NEIGHBOR TO CONTACT IN EMERGENCY. PLEASE DO NOT LIST ANYONE LIVING AT THE SAME ADDRESS AS YOURSELF.

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Number & Street City State Zip

RELATIONSHIP TO PATIENT: \_\_\_\_\_

**WE ARE REQUIRED BY LAW TO INCLUDE THESE QUESTIONS:  
You are not required to answer**

Do you have a living will? \_\_\_\_\_ durable power of attorney for health care? \_\_\_\_\_

If not, do you wish additional information? \_\_\_\_yes\_\_\_\_no

The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

